Breast and Cervical Eligibility Form

Eligibility-Enrollment Information

What is your age?	Family's yearly income before taxes?	Number of people in household?

Last Name	First Name	Middle Initial	Other Last Names Used
Birth Date	Social Security Number	State	County

Mailing Address	Street Address	City
Home/Cell Phone ( ) -	Work/Message Phone ( ) -	Zip

Insurance Information

☐ Yes ☐ No Referred to Marketplace for eligibility assessment for subsidized health insurance or Expanded Medicaid plans?

Date Referred_____
MM / DD / YYYY

☐ Yes ☐ No Do you have health insurance? Insurance Company _____

What is the co-insurance amount?_____ ☐ Yes ☐ No Do you have Medicaid?

What is the deductible amount?_____ ☐ Yes ☐ No Do you have Medicare Part B?

Ethnic Background

Are you Hispanic? (Spanish/Hispanic/Latino)

☐ Yes ☐ No ☐ Unknown

Race Which race(s) best describe(s) you?

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown

Medical Background

Are you having any breast problems? ☐ Yes ☐ No

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

Date of last mammogram _____
MM / DD / YYYY

Have you ever had a Pap test? ☐ Yes ☐ No

Date of last Pap test _____
MM / DD / YYYY

Have you ever had a hysterectomy? ☐ Yes ☐ No

Disability questions in cooperation with the Montana Disability and Health Program

☐ Yes ☐ No Are you deaf; Do you have difficulty hearing?

☐ Yes ☐ No Do you have difficulty dressing or bathing?

☐ Yes ☐ No Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

☐ Yes ☐ No Do you have serious difficulty walking or climbing stairs?

☐ Yes ☐ No Because of a physical, mental, or emotional condition do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

☐ Yes ☐ No Are you blind; Do you have serious difficulty seeing even when wearing glasses?

☐ Yes Do you decline to answer the disability questions?

Do you use tobacco ☐ Yes ☐ No If Yes, refer the client to the Montana Quit Line. 1(800) QUIT-NOW

How did you hear about the program? (Check all that apply)

☐Medical Provider ☐Internet ☐Pink/Purple Card (Pamphlets) ☐Re-screen/Previously Enrolled ☐Family/Friend/Word of Mouth

☐Presentation ☐MAIWHC ☐Fair-Job/Health or Pow Wow ☐Special Promotion/ Promotional Ad ☐Newspaper/Newsletter

☐Government Office ☐Radio ☐TV ☐ _____

Please READ and SIGN the Informed Consent and Authorization to Disclose Health Care Information

Office Use Only

Montana Cancer Control Programs Chronic Disease Prevention & Health Promotion Bureau	**Please Read and Sign**	MONTANA DPHHS Healthy People. Healthy Communities.

Client Name:	**Social Security Number:**

Informed Consent and Authorization to Disclose Health Care Information

The Montana Cancer Control Programs (MCCP) receives funds from the Center for Disease Control and Prevention (CDC) to provide cancer screening for age and income eligible Montana residents. Montana women can be screened through this program for breast and cervical cancers. Each time a client is screened for breast cancer, they may receive a clinical breast exam and breast X-ray called a mammogram. For cervical cancer, a client may receive a pelvic examination and a Pap test. If any of the initial tests for breast and cervical cancer are abnormal, further diagnostic testing may be required, which may include a diagnostic mammogram, ultrasound, and/or biopsy of the breast or cervical tissue. MCCP will provide patient navigation services that will help you complete all the diagnostic tests and find resources that may help for treatment (if necessary). By enrolling in the MCCP you are accepting responsibility for keeping appointments and completing all the screening and diagnostic tests that are recommended by your medical provider.

Services Not Covered

The MCCP only provides services for breast and cervical cancer screening and limited diagnostic tests. The program does not cover services for other health conditions, some diagnostic services, or cancer treatment. If I need services that are not covered, the MCCP staff will refer me to agencies that may help provide treatment. I understand that I may be billed for services not covered by the MCCP.

Insurance Information

I understand I have met the eligibility guidelines for the MCCP. I may have insurance coverage and still be eligible to participate. However, my insurance will be billed first for cancer screening services. If the services are not fully reimbursed by my insurance, the MCCP will pay the unpaid balance up to the maximum allowable Medicare reimbursement rate.

Confidentiality

Any information provided by me will remain confidential, which means that the information will be available only to me, my health care provider, and to the MCCP staff. The MCCP staff means those personnel and the Montana Department of Public Health and Human Services, administrative site and the tribal organizations and Indian Health Service Units who are specifically designated to work in the MCCP. Program reports will include information on groups of clients and will not identify any client by name or tribal affiliation.

Authorization to Disclose Health Care Information

I consent to and authorize the mutual exchange of screening and diagnostic records among the MCCP staff, my health care provider(s), the laboratory reading my Pap smear, and the radiology facility where my mammogram is performed with respect to MCCP related services received by me up to six months after the date indicated below. This authorization expires thirty months after the date I signed below.

I have read the information provided herein, discussed this and other information about the MCCP and agree to participate in the program. I have had an opportunity to ask questions about the MCCP and have received answers to any questions I had. All information, including financial and insurance benefits, I have provided to the MCCP is, to the best of my knowledge, true. I understand that my participation is voluntary and that I may drop out the MCCP at any time.

Client Signature: _____ **Print Full Name**: _____	**Date:** _____ MM / DD / YYYY